(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services)	TC is covered for persons 18 years of age or older who are not receiving care in a small and rural hospital. Medical necessity includes, but is not limited to, one or more of the following: 1. Intravenous therapy, including but not limited to: • single or multiple medications • blood or blood products • total parenteral nutrition • pain management • hydration Note: The clinical record must document failure of other preventive measures, failure or inappropriateness of non-intravenous medications or the patient's inadequate response to oral hydration.	Prior authorization is required for TC level of care. The attending physician must determine that the patient has been clinically stable for the 24 hours preceding admission to TC level of care. A definitive and time-limited course of treatment must be developed prior to admission by the physician assuming TC treatment management. The attending physician must perform the initial medical visit within 24 hours of the patient's admission to TC level of care. For patients admitted from acute care hospitals, if the physician assuming the responsibility for treatment management in TC was also the attending physician in the acute care hospital, the initial physician visit must occur within 72 hours.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1 Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	2. Rehabilitative services, including physical therapy, occupational therapy, and speech therapy rendered to: A. The transitional rehabilitation patient, who, prior to admission to TC, meets all the following criteria: • Has been assessed by a physiatrist or physician otherwise skilled in rehabilitation medicine, who has provided an explicit, time-limited plan of treatment; • Has sufficient endurance to participate in a minimum of one hour a day, 5 days per week, of a single or combined rehabilitative therapy, as ordered by a physiatrist or physician otherwise skilled in rehabilitation medicine, provided by, or under the direct supervision of, a licensed or registered therapist; and	The attending physician must visit the TC patient at least twice weekly or more often as the patient's condition warrants while the patient is receiving TC level of care. A certified nurse practitioner, in collaboration with the attending physician, or physician's assistant, under the supervision of a physician, may provide non-duplicative services to TC patients. Leave of absence is covered for TC Rehabilitation patients only. TC patients require care by registered nurses on every shift.

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

(Note: This chart is an overview only.)

TYPE OF SERVICE		PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1	Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	• Has potential to make significant functional gain in a reasonable period of time or has a caregiver available to participate in short-term training that will enable the patient to return safely to a residential environment with the caregiver's assistance. B. The transitional medical patient, who has a need for rehabilitation therapy as ordered by the physician.	Not covered by TC: • Obstetrical patients • Patients receiving anti-cancer intravenous cytotoxic drugs • Patients with highly complex multiple rehabilitation needs that include intensive social and/or psychological interventions in order to adjust to their disability or in order to be discharged safely to a residential setting • Patients with a primary psychiatric diagnosis, or any disorder resulting in behaviors that require an intensive, highly structured behavior management and/or cognitive retraining program

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

TYPE OF SERVICE		PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
1.1	Transitional Inpatient Care (TC) (Inpatient Hospital Services) (continued)	3. Wound care, including but not limited to, skin ulcers, pressure sores, open surgical sites, fistulas, tube sites and tumor erosion sites requiring the implementation of a wound care plan every eight hours. Wounds that pre-existed at nursing facility-level B shall not qualify for TC level of care. Wound care management requires physician prescribed intervention by the licensed nurse and/or physical therapist beyond routine cleansing and dressing. 4. Respiratory treatments requiring medication administration by a licensed nurse or respiratory therapist at least every six hours. 5. Traction, requiring the assessment and intervention of a licensed nurse or licensed physical therapist at least every eight hours.	

* Prior authorization is not required for emergency services.
** Coverage is limited to medically necessary services.

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
2a Hospital outpatient department services and organized outpatient clinic services	The following services are covered: 1. Physician 2. Optometric 3. Psychology 4. Podiatric 5. Physical therapy 6. Occupational therapy 7. Speech pathology 8. Audiology 9. Acupuncture 10. Laboratory and X-ray 11. Blood and blood derivatives 12. Chronic hemodialysis 13. Hearing aids 14. Prosthetic and orthotic appliances 15. Durable medical equipment 16. Medical supplies 17. Prescribed drugs 18. Use of hospital facilities for physicians' services 19. Family planning 20. Adult day health care	Prior authorization is always required for physical therapy; chronic hemodialysis; purchase, rental, or repair of hearing aids if cost exceeds $25; adult day health care; surgical procedures considered to be elective; outpatient heroin detoxification; outpatient procedures such as hyperbaric O_2 therapy, psoriasis day care, pheresis, and cardiac catheterization. Prior authorization is required for psychiatry visits in excess of 8 in 120 days and for allergy injections in excess of 8 in 120 days. Speech pathology and audiology, occupational therapy, acupuncture, and psychology services are subject to the availability of MEDI labels. Routine podiatry office visits are allowed without prior authorization. All other podiatry services are subject to prior authorization. Prior authorization is required when the purchase price of durable medical equipment or prosthetic, orthotic appliances exceeds $100. Prior authorization is required when cummulative rental or repairs exceed $25.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPHA88 17

Eff 7-1-88

App. MAY 2 1 1989

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
			All services, including physicians' services are subject to the same requirements as when provided in a nonfacility setting. Mental health services are identified in the SD/MC agreement, along with the appropriate utilization controls for that delivery system. Beneficiaries may elect to receive service through either the regular Medi-Cal program or the SD/MC system.
2b	Rural health clinic services and other ambulatory services courses under the state plan.	Physician services and home nursing services in those areas having a shortage of home health agencies are covered.	Home nursing services must be furnished in accordance with a written treatment plan established by a physician or nonphysician medical practitioner. The treatment plan must be approved and reviewed every 60 days by the supervising clinic physician. All services, including physicians' services, are subject to the same requirements and limitations as when provided in a nonfacility setting.
2c and 2d	Federally qualified health center (FQHC) services and other ambulatory services covered under the state plan.	Physician services and home nursing services provided by a FQHC.	All services, including physicians' services, are subject to the same requirements and limitations as when provided in a nonfacility setting.

* Prior authorization is not required for emergency service.
** Coverage is limited to medically necessary services.

State/Territory: CALIFORNIA

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   [X] Provided: [ ] No limitations [X] With limitations*

2. a. Outpatient hospital services.

   [X] Provided: [ ] No limitations [X] With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic.

   [X] Provided: [ ] No limitations [X] With limitations*

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with Section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   [X] Provided: [ ] No limitations [X] With limitations*

   d. Ambulatory services offered by a health center receiving funds under Section 329, 330, or 340 of the Public Health Service Act to a pregnant woman or individual under 18 years of age.

   [X] Provided: [ ] No limitations [X] With limitations*

3. Other laboratory and X-ray services.

   [X] Provided: [ ] No limitations [X] With limitations*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

   [X] Provided: [ ] No limitations [X] With limitations*

   b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.

   [X] Provided: [ ] No limitations [X] With limitations*

   c. Family planning services and supplies for individuals of childbearing age.

   [X] Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

(Note: This chart is an overview only.)

	TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
3	Laboratory, radiological, and radioisotope services	As required on order of a licensed practitioner except laboratory services provided in renal dialysis centers and community hemodialysis units are payable only when billed by the center or unit.	Prior authorization is required for nonemergency portable X-ray services unless performed in a skilled nursing facility (SNF) or intermediate care facility (ICF).
4a	Skilled nursing facility	Covered when patient has need for daily skilled nursing and/or daily special rehabilitation services which, as a practical matter, can only be provided on an inpatient basis. The patient must be visited by a physician at least monthly for the first three months and at least every two months thereafter.	Prior authorization is required. Attending physicians must recertify a patient's level of care and plan every 60 days. For patients having Medicare as well as Medi-Cal eligibility (crossover cases), authorization is required at the time of Medicare denial or on or before the 20th day after admission.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPWH#88-07

Eff 7-1-88

App MAR 31 1989

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
4a.1 Subacute care services (SNF)	This is a more intensive SNF level of care. Covered when patient has need for intensive licensed skilled nursing care. The patient must be visited by a physician at least twice weekly during the first month and a minimum of at least once every week thereafter. Subacute units must provide sufficient licensed nursing staff to provide a minimum daily average of 4.8 actual licensed nursing hours per patient day for nonventilator-dependent patients and 6.2 licensed nursing hours per patient day for ventilator-dependent patients.	Same as 4a above. Initial care may be authorized for up to two months. Prolonged care may be authorized for up to a maximum of four months.

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPHH 88-17

Eff 7-1-88

App

1989

(Note: This chart is an overview only.)

TYPE OF SERVICE	PROGRAM COVERAGE**	PRIOR AUTHORIZATION OR OTHER REQUIREMENTS*
	Minimal standards of medical necessity for the subacute level of care include: A. Physician visits medically required at least twice weekly during the first month and a minimum of at least once every week thereafter. B. Twenty-four hour access to services available in a general acute care hospital. C. Special equipment and supplies such as ventilators. D. Twenty-four hour nursing care by a registered nurse or licensed vocational nurse.	

* Prior authorization is not required for emergency service.

** Coverage is limited to medically necessary services.

SPHMCC-17

Eff 9-1-88

App MAR 2 1 1989